U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue date: 22Mar2001

CASE NO. 2000-BLA-106

In the Matter of

LONDON SIMS .
Claimant

v.

U.S. STEEL MINING COMPANY, INC.
Employer

and

USX CORPORATION
Carrier

and

DIRECTOR, OFFICE OF WORKERS
COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:

Thomas E. Johnson, Esquire
For the Claimant

James N. Nolan, Esquire
For the Employer/Carrier

Before: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on September 19, 2000 in Birmingham, Alabama. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued.

Due to multiple errors in Claimant's submissions, a clarification of the exhibits in evidence is required. First, Claimant submitted Dr. Robert Cohen's Consulting Medical Evaluation, dated August 29, 2000, and curriculum vitae, under cover letter, dated August 30, 2000. The foregoing was identified as Claimant's Exhibit 1. However, as stated at the hearing, Claimant provided an updated or substitute Claimant's Exhibit 1 (TR 14, 37) under cover letter, dated September 21, 2000. Accordingly, the document previously marked as Claimant's Exhibit 1 is excluded and replaced by the corrected document, which has been marked as "CX 1." Secondly, Clamant submitted a two-page document, which was identified as a CT scan reading by Dr. Egiebor dated November 19, 1999. The foregoing document was marked as Claimant's Exhibit 8. Although the Claimant's submission of this document did not comply with the 20-day rule, the Employer waived its objection subject to its right to respond thereto (TR 7, 9-10). Having reviewed the above-referred CT scan interpretation document, I find that the document is a poor quality copy of a facsimile transmission. Except for the name of the reader (*i.e.*, Dr. Osbert Egiebor) the only legible name on the document is "COHEN, MARDGE." There is no reference whatsoever to the Claimant, London Sims. Therefore, the foregoing CT scan,

---

[1]Amendments to Part 718 of the regulations are set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations were to become effective on January 19, 2001 and apply to both pending and newly filed cases. The revised regulations have not affected the outcome of this decision. Specifically Section 718.204 has not affected the outcome of the case because the pulmonary function and arterial blood gas study tables in Appendices B and C have not changed, and, as under the previous regulation, a physician's documented and reasoned medical judgment may establish total disability. Further, as the treating physician's opinion in this case was developed on or before January 19, 2001, the new regulation governing treating physicians' opinions set forth in 20 C.F.R. Section 718.104(d) does not apply. This decision is consistent with existing judicial precedent and is not affected by the proposed regulatory changes. The new Part 725 regulations also were to become effective on January 19, 2001. However, the new procedural aspects of the Part 725 regulations only apply to claims filed on or after January 19, 2001.

which was formerly identified as Claimant's Exhibit 8, does not pertain to the Claimant. Accordingly, it is struck from the record. Finally, Claimant's counsel submitted three post-hearing exhibits under cover letter, dated November 15, 2000, which he identified as Claimant's Exhibits 8, 9 and 10, respectively. The new "Claimant's Exhibit 8" is Dr. Ahmed's November 6, 2000 interpretation of a chest x-ray, dated August 18, 1999 (CX 8).[2]

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 65 (DX 1-65), Administrative Law Judge Exhibits 1 and 2 (ALJX 1-2), Claimant's Exhibits 1 through 10 (CX 1-10), and Employer's Exhibit 1 (EX 1).[3] In addition, the post-hearing briefs filed by the respective parties have been received and considered.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

The Claimant, London Sims, filed his initial application for benefits under the Act on November 13, 1973 (DX 19-1). The claim was repeatedly denied, most recently on December 11, 1979 (DX 19-12). Since the Claimant did not appeal nor take any further action within one year thereof, the above referred application is deemed finally denied and administratively closed.

Claimant filed a second application for benefits on April 12, 1989 (DX 20-1), which was denied by the Deputy Commissioner (now known as the District Director) on August 4, 1989 (DX 20-16). Claimant did not appeal nor take any further action within one year thereof. Therefore, the second application is also deemed finally denied and administratively closed.

The current claim was filed on August 10, 1992 (DX 1). The claim was denied by the District Director's office on January 15, 1993 (DX 17). Pursuant to Claimant's timely request, a formal hearing was held before Administrative Law Judge Lawrence E. Gray on October 26, 1993 (DX 25). Thereafter, Judge Gray issued a Decision and Order Awarding Benefits, dated April 29, 1994 (DX 28). On appeal, the Benefits Review Board (hereinafter "the Board") affirmed in part, vacated in part,

---

[2]As stated in Claimant's post-hearing brief, note 3, there were two documents identified as CX 8. Counsel suggested that Dr. Egiebor's CT scan interpretation remain as CX 8, and Dr. Ahmed's x-ray reading be marked as "CX 8B." However, since Dr. Egiebor's CT scan interpretation has been excluded, I have simply marked Dr. Ahmed's x-ray reading as "CX 8."

[3]Pursuant to leave granted at the formal hearing, Claimant's and Employer's post-hearing submissions were marked as Claimant's Exhibits 8 through 10 (CX 8-10) and Employer's Exhibit 1 (EX 1), respectively, and have been received in evidence (TR 11-14, 37).

and remanded the case. The Board affirmed the following findings: coal mine employment of at least 37 years 2 months; a material change in conditions was established under § 725.309; the existence of pneumoconiosis was established under § 718.202(a)(1); the disease arose from coal mine employment under § 718.203(b); and, total disability was not established under § 718.204(c)(1)-(3). The basis for the Board's decision to vacate and remand Judge Gray's decision involved his finding of total disability under § 718.204(c)(4) and his failure to weigh all the probative and contrary probative evidence at 20 C.F.R. § 718.204(c). (DX 37).

On remand, the case was re-assigned to Administrative Law Judge Edward J. Murty, Jr., who issued a Decision and Order, dated August 10, 1995, denying benefits (DX 41). In his decision, the administrative law judge concluded that "a finding of pneumoconiosis cannot be sustained." Furthermore, Judge Murty stated that the "Claimant has not proven total disability." (DX 41). On appeal, the Board issued a Decision and Order, dated December 19, 1996, which vacated Judge Murty's decision and remanded the case for further consideration consistent with its opinion (DX 47). The Board held that Judge Murty had exceeded the scope of the Board's remand order, and it re-affirmed Judge Gray's finding that the Claimant has established the existence of pneumoconiosis under § 718.202(a)(1). Furthermore, the Board directed Judge Murty to reevaluate the medical opinion evidence under § 718.204(c)(4), and the causation issue under § 718.204(b). (DX 47).

Following the Board's second remand, Judge Murty issued another Decision and Order denying benefits, dated March 31, 1997 (DX 48). Notwithstanding the instructions of the Board, Judge Murty, again, found that neither pneumoconiosis nor total disability had been established (DX 48). On appeal, the Board issued a Decision and Order, dated May 7, 1998, in which Judge Murty's May 31, 1997 decision was affirmed in part, vacated in part, and remanded for further consideration (DX 56).

Following the Board's third remand, Judge Murty issued a Decision and Order, dated July 23, 1998, in which he denied benefits solely on the grounds that the Claimant had failed to establish total disability (DX 57). In making this determination, Judge Murty stated that there was no evidence that the Claimant had complicated pneumoconiosis; none of the five pulmonary function studies were qualifying; none of the seven sets of arterial blood gas studies were qualifying; there was no evidence of cor pulmonale with right sided congested heart failure; and, the better reasoned and documented medical opinion evidence did not establish the presence of a totally disabling respiratory or pulmonary impairment (DX 57). Although the Claimant did not appeal Judge Murty's most recent decision, Claimant did file a timely petition for modification on March 3, 1999 (DX 58). Thereafter, the Employer controverted the claim (DX 60). Following the development and submission of additional evidence, an informal conference was held on May 11, 1999. Subsequently, the District Director issued a Proposed Decision and Order Memorandum of Conference, dated September 20, 1999, denying benefits on the basis of the Claimant's failure to establish total disability (DX 63). On or about October 19, 1999, the Claimant filed a timely request for a formal hearing (DX 64). On November 4, 1999, the case was forwarded to the Office of Administrative Law Judges (DX 65). As stated above,

a formal hearing was held before the undersigned on September 19, 2000.

Issues

On the Form 1025 transmittal sheet, the Employer reportedly contested the following issues:

1. Whether the miner has pneumoconiosis as defined by the Act and the regulations.
2. Whether the miner's pneumoconiosis arose out of coal mine employment.
3. Whether the miner is totally disabled.
4. Whether the miner's disability is due to pneumoconiosis.
5. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c),(d).
6. Whether the evidence establishes a change in conditions and/or a mistake in a determination of fact in the prior denial per 20 C.F.R. § 725.310.

(DX 65).

The Employer conceded that the Claimant engaged in coal mine employment for 37 years (TR 15). Furthermore, in its Post-Hearing Brief, Employer acknowledged that it is the properly named responsible operator (Employer's Post-Hearing Brief, p. 2). Moreover, Employer's counsel also stated, in pertinent part: "The employer concedes that the weight of the evidence compels a finding that the miner does suffer from pneumoconiosis..." (Employer's Post-Hearing Brief, p. 6). Since the "pneumoconiosis" issue was one of the elements previously adjudicated against the Claimant in the final denial of the prior claim (DX 20-16), the finding of pneumoconiosis in the current case establishes a material change in conditions as a matter of law. 20 C.F.R. § 725.309. Accordingly, the only remaining contested issues are as follows:

1. Whether the miner's pneumoconiosis arose out of coal mine employment.
2. Whether the miner is totally disabled.
3. Whether the miner's disability is due to pneumoconiosis.
4. Whether the evidence establishes a change in conditions and/or a mistake in a determination of fact in the prior denial per 20 C.F.R. § 725.310.

Findings of Fact and Conclusions of Law

Background and Employment History

The Claimant, London Sims, was born on March 30, 1927. He has no dependents for the purpose of possible augmentation of benefits under the Act. (DX 1; TR 16).

The parties stipulated, and I find, that the Claimant engaged in coal mine employment for at

least 37 years (TR 15-16). All of Claimant's coal mine employment was spent in underground mines (TR 16-17). Claimant testified that his last usual coal mine job was as a motor man (TR 18). The job required the Claimant to drive the motor and deliver supplies (TR 24). However, Claimant testified that the job also entailed considerable physical exertion, including extensive walking, hauling, loading and unloading equipment and material, such as rock dust bags, cement, oil barrels, and timber (TR 18-31). Claimant left the coal mines in 1989, when he retired at age 62 (TR 18, 31).

Claimant testified that he first noticed his breathing problems in the 1970's. His condition has worsened over the years. Claimant stated that sometimes he can only walk about one-half block, and that he has to stop three or four times climbing one flight of stairs (TR 32). In addition, Claimant stated that his shortness of breath makes it difficult for him to sleep. Furthermore, Claimant testified that he has a coughing problem. Claimant's treating physician is Dr. David Hall, who has treated him for approximately eight years. He prescribed an inhaler and some pills for Claimant's breathing problems (TR 33-34).

Claimant acknowledged a cigarette smoking history of approximately two packs per week or less for 39 years ending in 1988 (TR 35-36). Claimant also stated that he suffered fractured ribs and a hip injury in a serious car accident in 1977. However, Claimant returned to the mines after the accident and continued to engage in coal mine employment until 1989 (TR 36-37).

Medical Evidence

The medical evidence includes various x-ray interpretations, pulmonary function studies, arterial blood gases, and physicians' opinions.

The case file contains interpretations of chest x-rays dated December 7, 1973 (DX 19), September 8, 1979 (DX 19), November 17, 1988 (DX 22), May 16, 1989 (DX 20), September 11, 1989 (DX 58), October 21, 1992 (DX 9, 10, 11), September 10, 1998 (DX 62), August 18, 1999 (DX 62; CX 8, 9, 10), and November 16, 1999 (CX 2, 4, 5, 6; EX 1).

The preponderance of the *early* x-ray evidence covering the period from December 7, 1973 through September 11, 1989 was negative for pneumoconiosis. The October 21, 1992 readings were mixed, with the majority of such interpretations positive for pneumoconiosis. The descriptive interpretation of the September 10, 1998 film neither precludes nor establishes pneumoconiosis. However, the August 18, 1999 and November 16, 1999 have repeatedly been interpreted as positive for pneumoconiosis by numerous physicians, including Drs. Hasson (DX 62), Ahmed (CX 6, 8), Miller (CX 5, 9), Cappiello (CX 4, 10), Cohen (CX 2), and Wiot (EX 1). In view of the progressive and irreversible nature of pneumoconiosis greater weight is generally accorded the more recent medical data. Furthermore, except for Dr. Hasson, whose radiological credentials were not given, all of the above-named physicians are B-readers. Accordingly, taken as a whole, I find that the x-ray evidence is positive for pneumoconiosis.

In considering the x-ray evidence, I note that Dr. Cohen reported Size A large opacities on the November 16, 1999 chest x-ray (CX 2). If credited, such a reading would meet the regulator criteria for *complicated* pneumoconiosis. However, I find that Dr. Cohen's interpretation is outweighed by those of other B-readers, such as Drs. Ahmed (CX 6), Miller (CX 5), Cappiello (CX 4), and Wiot (EX 1), who interpreted the same film as positive for only *simple* pneumoconiosis. Therefore, I find that the x-ray evidence is positive for *simple* pneumoconiosis, but negative for complicated pneumoconiosis.

The record also contains pulmonary function studies administered on September 8, 1979 (DX 19), May 16, 1989 (DX 20), September 11, 1989 (DX 22), October 21, 1992 (DX 6), September 22, 1998 (DX 62), August 18, 1999 (DX 62), November 19, 1999 (CX 2), and August 1, 2000 (CX 3). None of the foregoing are qualifying under the applicable regulatory criteria set forth in Part 718, Appendix B.

The record also includes arterial blood gas tests which were administered on September 8, 1979 (DX 19), May 16, 1989 (DX 20), September 11, 1989 (DX 22), October 21, 1992 (DX 8), September 22, 1998 (DX 62), August 18, 1999 (DX 62), November 19, 1999 (CX 2), and August 1, 2000 (CX 3). None of the foregoing are qualifying under the applicable regulatory criteria set forth in Part 718, Appendix C.

The medical opinion evidence consists of the findings and/or opinions of Drs. Hasson (DX 19, 62), Goldstein (DX 20), Hall (DX 22; CX 7), Russakoff (DX 7), Vincent (DX 22), Waldrum (DX 58, 61, 62), and Cohen (CX 1).

Dr. Jack H. Hasson conducted his initial examination of the Claimant on September 8, 1979 (DX 19-5). At that time, Dr. Hasson found "no evidence of pneumoconiosis radiographically." Although Dr. Hasson found some abnormalities on physical examination such as decreased breath sounds, the clinical results of pulmonary function testing and arterial blood gas studies were interpreted as either "within normal limits," or as showing only "minimal" or "slight" abnormalities (DX 19-4).

Dr. Hasson conducted a significantly more recent pulmonary evaluation of the Claimant on August 18, 1999 (DX 62). Based upon the Claimant's history, physical findings on examination, chest x-ray reading, an EKG, pulmonary function study, and arterial blood gases, Dr. Hasson concluded:

> PROBLEMS:
> 1. Simple pneumoconiosis T/Q, 1/1 in perfusion.
> 2. History of prostatectomy and hernia repair.
> 3. Previous motor vehicle accident with rib fractures on the left with resultant elevation of diaphragm and rib fracture changes.
> 4. Atherosclerotic cardiovascular disease with peripherovascular disease, with history of surgery in the past. Using a cane to walk, and has carotid bruit.

DISCUSSION: The patient does have a history, physical examination, laboratory data and x-ray consistent with mild pneumoconiosis. His pulmonary impairment is mild.

(DX 62).

Dr. Allan R. Goldstein examined the Claimant on May 16, 1989 (DX 20-9). Dr. Goldstein reported Claimant's history, subjective complaints, physical findings, some abnormalities on chest x-ray other than pneumoconiosis, a "restrictive defect" on pulmonary function study, "normal" arterial blood gases, and an EKG within normal limits. Dr. Goldstein set forth specific information regarding the Claimant's smoking history, but simply noted "see attached" regarding Employment History. Based upon the foregoing, Dr. Goldstein set forth the following cardiopulmonary diagnoses: "1. Chest pain. 2. Dyspnea. 3. Chronic bronchitis. 4. Restrictive lung disease." Regarding the first two diagnosed conditions, Dr. Goldstein noted: "Must rule out coronary artery disease." Furthermore, he related the third and fourth diagnoses to smoking and chest wall injury, respectively. Finally, Dr. Goldstein stated: "Impairment may be cardiac in origin - not enough information available. If pulmonary disease only doubt degree of dyspnea due to chronic bronchitis is significant." (DX 20-9).

The case file contains a note by Dr. David B. Hall, dated February 5, 1990, which states that the Claimant had multiple health problems, including peripheral vascular disease, coal worker's pneumoconiosis, and COPD (DX 22, p. 16).

In a supplemental report, dated August 9, 2000 (CX 7), Dr. Hall stated that he had been treating the Claimant for the past eight years. Dr. Hall reported that the Claimant "suffers from restrictive and mild obstructive lung disease." He set forth the Claimant's employment and smoking histories, and, Claimant's complaints of significant respiratory impairment which severely limits his ability to walk. Furthermore, Dr. Hall noted that the Claimant's last coal mine job entailed walking and unloading material which weighed up to 100 pounds. In addition, Dr. Hall interpreted arterial blood gas test results. In conclusion, Dr. Hall stated, in pertinent part:

> I feel that the significant amount of restrictive lung disease that he suffers with is related to his 37 years of mine employment and within a reasonable degree of medical certainty is due to coal dust exposure. The patient's recent cardiopulmonary exercise study was limited due to submaximal exercise, but it is noted that he had abnormal gas exchange with exercise and reduced work capacity though essentially normal cardiac indices. I feel this substantiates my impression that his problems relate chiefly to pulmonary rather than cardiac etiologies.
>
> I feel that Mr. London Sims is totally disabled from any meaningful employment that would require anything other than completely sedentary activity based on his decreased exertion capacity. This is directly related to his coal workers' pneumoconiosis.

(CX 7).

Dr. A. David Russakoff examined the Claimant on October 21, 1992 (DX 7). On the Department of Labor form report, Dr. Russakoff set forth the Clamant's history, subjective complaints of dyspnea, productive cough, chest pain, orthopnea, and paroxysmal nocturnal dyspnea; chest x-ray findings of pneumoconiosis and abnormalities related to a car accident; "minimal restrictive ventilatory impairment" on pulmonary function test; "normal resting arterial blood gases, but with a "profound drop in PO2 with minimal exercise indicative of underlying lung disease." Based upon the foregoing, Dr. Russakoff set forth the following cardiopulmonary diagnoses: pneumoconiosis, minimal; left linear fibrosis with elevation of left hemidiaphragm and healed multiple rib fractures secondary to previous chest trauma from automobile accident; and, S/P arterial embolus to right lower extremity S/P embolectomy. Dr. Russakoff also stated that the etiology of the Claimant's pneumoconiosis was his longstanding history of coal dust exposure. Regarding the degree of respiratory or pulmonary impairment, Dr. Russakoff stated:

> There is minimal impairment of the respiratory system. The minimal restrictive disease, however, is thought to be related to his elevated diaphragm, rib fractures and fibrosis, rather than the minimal pneumoconiosis seen. It is also apparent that the minimal impairment of lung function was not a factor in his inability to work as he worked until retirement in 1989. However, he does have significant impairment in diffusion of oxygen with minimal exercise, as noted on blood gas testing although not to the extent of causing hypoxia. However, had he been able to exercise further this might yet have developed. If in fact that was the case, then there would be significant impairment in his ability to perform heavy physical exertion.

(DX 7).

Dr. Arthur H. Vincent issued a medical report, dated October 2, 1993 (DX 22). Dr.Vincent stated that he had first examined the Claimant on August 24, 1989 regarding complaints of shortness of breath. Dr. Vincent reported a fairly accurate coal mine employment history ("over 40 years," instead of 37 years), documented breathing problems dating back to 1985, some abnormalities on chest x-ray, physical findings of a few crackles but otherwise normal, reduced pulmonary function values "indicating airway obstruction," and reduced PCO2 values at rest and exercise. Based upon the foregoing, Dr. Vincent concluded:

> In my opinion the patient the patient (sic) is totally disabled for gainful employment due to his shortness of breath related to his having worked in the mines over 40 years. Because of the patient's age and length of time the patient has had his shortness of breath I see no improvement in the foreseeable future.
>
> Final diagnoses: 1. Shortness of breath due to chronic obstructive pulmonary disease

superimposed on pneumoconiosis.

(DX 22).

Dr. Michael R. Waldrum, who is Board-certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine (DX 58), examined and treated the Claimant at the Kirklin Clinic-Pulmonary Medicine (DX 61,62). The initial examination was conducted on September 22, 1998. Dr. Waldrum set forth the Claimant's history, subjective complaints, physical findings, and the results of various clinical tests, including chest x-ray, pulmonary function studies, and arterial blood gases. Dr. Waldrum diagnosed "reticular nodular interstitial changes on chest x-ray that may be consistent with an underlying coalworker's pneumoconiosis or occupational lung disease." In addition, Dr. Waldrum noted that Claimant also had exposure to asbestos with his previous work, which may account for some of the changes on chest x-ray. Dr. Waldrum stated that the "pulmonary function studies do not indicate a significant amount of obstruction or restriction at this time, although he does have a reduction in diffusion capacity." However, the crux of Dr. Waldrum's treatment plan involved Claimant's complaints of worsening chest pain and his cardiac condition (DX 61, 62).

In a clinic note, dated October 29, 1998, Dr. Waldrum reported that he was following the Claimant for the following conditions: peripheral vascular disease, status post fem-op on the right side, 1990; prostate cancer, status post prostactectomy in 1990 "Co-worker's (sic) pneumoconiosis;"[4] and probable coronary artery disease. Dr. Waldrum's assessment/plan notation stated that the Claimant "likely has CWP and also probable coronary artery disease." He was awaiting outside films for a further determination about the Claimant's occupational lung disease (DX 61, 62).

The clinic note, dated January 26, 1999, again, lists the above-stated conditions, but avoids the above-referred typographical error by simply listing "CWP" among the conditions. Dr. Waldrum, agin, set forth Claimant's history, physical findings, and the results of clinical data, such as a chest x-ray and cath report. Based upon the foregoing, Dr. Waldrum stated:

> ASSESSMENT/PLAN: Mr. Sims appears to have CWP. He is stable with this and his other medical problems. I feel he has CWP considering his occupational exposure and his chest x-ray findings. The difficult thing to determine is the amount of impairment this is causing him. In order to quantitate this more, an exercise study could be done but I will not o this unless I need it in the future. I plan to continue the same therapy as is today. He will contact me if needed otherwise I plan to see him back in six months with a chest x-ray.

---

[4]In testimony at deposition, Dr. Waldrum confirmed that this is a "typo" and that he meant "coal worker's pneumoconiosis." (DX 62, Waldrum deposition, p. 44).

(DX 61, 62).

The record also contains a supplemental letter, dated May 26, 1999, signed by Dr. Waldrum (DX 61, 62). The letter states that Dr. Waldrum was responding to questions posed by Michael E. Bevers, Esq., and that the answers were "based on my treatment of London Sims and the information you submitted to me. The information includes an affidavit from a Mr. Bobby Bailey describing the physical requirements of the job of motorman, a job description from the Department of Labor file, a job description from the Dictionary of Occupational Titles, and my records of treating Mr. Sims." Dr. Waldrum summarized Claimant's coal mine employment and smoking histories, various clinical test results obtained in 1992, and discussed the chest x-ray evidence. In conclusion, Dr. Waldrum stated:

> My opinions, based on the factors discussed above, is that Mr. Sims can no longer work as a motorman. This is due at least in part to his pulmonary impairment. Although Mr. Sims has not sustained the respiratory impairment many coal miners have sustained, the physical requirements of his job impose a level of exertion Mr. Sims could not sustain with his pulmonary function.

(DX 61, 62).

In testimony at deposition held on August 17, 1999, however, Dr. Waldrum acknowledged that he did not draft the foregoing letter, but rather it was presented to him for "review and execution" (DX 62, Waldrum deposition, p. 33). On the other hand, Dr. Waldrum testified: "I read it completely and thought that it accurately represented my views." (DX 62, Waldrum deposition, p. 35). However, with respect to the total disability issue, Dr. Waldrum stated that he was not rendering an opinion as to whether the Claimant could perform the work of a motorman in a clean environment, but rather he was simply saying that the Claimant cannot perform work in a dusty environment (DX 62, Waldrum deposition, pp. 40-41). In fact, despite positive x-ray evidence of pneumoconiosis and Claimant's symptoms, Dr. Waldrum stated that the pulmonary function results indicated "minimal to no impairment." (DX 62, Waldrum deposition, p. 37). Finally, Dr. Waldrum testified:

> I have done nothing in this evaluation, as I stated in my clinic note, to evaluate him for a level of physical impairment. It's my opinion, though, that patients that have symptoms and have objective findings that are consistent with coal workers' pneumoconiosis, that they should not be - - have an ongoing exposure to the things that - - I believe the coal - - the coal companies generally believe the same thing.

(DX 62, Waldrum deposition, p. 54).

Dr. Robert Cohen, who is Board-certified in Internal Medicine and Pulmonary Disease, issued a report, dated August 29, 2000 (CX 1). Dr. Cohen cited a medical evaluation performed at Cook County Hospital on November 16, 1999, and a follow-up visit on August 1, 2000. Furthermore, Dr.

Cohen's report sets forth a summary of the available medical data. Based upon the foregoing, Dr. Cohen opined that "Mr. Sims does indeed suffer from coal workers pneumoconiosis. I believe his chronic respiratory impairment is substantially related to his over 30 years of coal mine employment." (CX 1, p. 14). Regarding the total disability and causation issues, Dr. Cohen stated:

> Mr. Sims's record has numerous pulmonary function tests, which demonstrate a clear mild restrictive impairment with a moderately impaired FEV1 (64% of predicted) and severe diffusion impairment (36% of predicted) with an altered gas exchange abnormality consistent with coal worker's pneumoconiosis of a high dead space to tidal volume ratio of 41% in the first study and 37% in the second. He had a positive alveolar to end tidal C02 gradient at peak exercise. His Alveolar to arteriolar oxygen gradient widened by nearly 10 mmhg after only 3.5 minutes of exercise, another sign of significant gas exchange abnormality. I do not believe that Mr. Sims could carry out the extremely heavy exertion required by his last coal mine job due to his severe diffusion impairment, restrictive impairment, and gas exchange abnormality noted with exercise. His diffusion impairment would be predictive of a significant exercise limitation...(footnote to medical literature omitted)...We were not able to demonstrate this completely in te exercise laboratory due to Mr. Sims' inability to achieve a maximal exercise test. It is also important to consider that Mr. Sims' last coal mining job as a motorman required significant heavy exertion. He often had to walk several miles to get to his destination with up to 3/4 of a mile up an incline. He had to lift buckets of gear weighing 75 pounds, 50 bags of crete, and 100 bags of lime dust for one hour each day. I do not believe he wold have the pulmonary capacity to perform this work based on the severe diffusion impairment and mild restrictive impairment detected on his pulmonary function testing.
>
> Conclusion:
>
> The sum of the medical evidence in conjunction with this patient's work history indicates that this patient's more than 30 years of underground coal dust exposure was significantly contributory to the development of his mild restrictive defect and severe diffusion impairment. It also resulted in Category A complicated pneumoconiosis with a background of category 1 simple pneumoconiosis. His respiratory impairment was disabling for his last coalmine employment as a motorman.

(CX 1).

Discussion and Analysis

Pneumoconiosis

As summarized above, although the early x-ray evidence is negative or mixed, the more recent x-ray readings have consistently been positive for pneumoconiosis. Accordingly, I find that the Claimant has established the presence of pneumoconiosis under § 718.202(a)(1). Furthermore, the preponderance of the recent medical opinion evidence also establishes pneumoconiosis under the provisions of § 718.202(a)(4). The foregoing finding of pneumoconiosis is consistent with the Employer's concession regarding this issue, as set forth in its brief. (*See* Employer's Post-Hearing Brief, p. 6).

Causal Relationship

Since the Claimant has established the existence of pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. § 718.203. I find that the presumption set forth in § 718.203 has not been rebutted. To the contrary, the physicians who found pneumoconiosis and addressed this issue attributed the disease to Claimant's coal mine employment.

Total Disability

As discussed above, the record does contain some evidence of *complicated* pneumoconiosis; namely, Dr. Cohen's x-ray reading of the November 16, 1999 film (CX 2) and Dr. Cohen's report, dated August 1, 2000 (CX 1). However, Dr. Cohen's x-ray finding is far outweighed by the other x-ray evidence. Furthermore, except for his own x-ray reading, Dr. Cohen provided no basis for his diagnosis of complicated pneumoconiosis. Accordingly, I find that the Claimant has failed to establish the presence of *complicated* pneumoconiosis. Therefore, he is not entitled to the irrebuttable presumption of total disability due to pneumoconiosis, as set forth in § 718.304 and § 718.204(b)(1).

In a living miner's claim, the amended regulations at § 718.204(b)[5] provide the following four methods to establish total disability: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; and (4) reasoned medical opinions.

Section 718.204(b)(2)(i) provides for a finding of total disability when there are pulmonary function studies with FEV1 values equal to or less than those listed in the tables and either FVC equal to or below listed table values; or MVV values equal to or below listed table values; or a percentage of 55 or less when the FEV1 test results are divided by the FVC results. As stated above, none of the pulmonary function studies are qualifying. Accordingly, total disability cannot be established under this subsection.

[5]Prior to the most recent amendments, almost identical provisions were found in 20 C.F.R. § 718.204(c).

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. As previously stated, none of the arterial blood gas tests are qualifying. Therefore, the Claimant has not established total disability under this subsection.

The provisions of § 718.204(b)(2)(iii) are inapplicable because there is no evidence of cor pulmonale or right-sided congestive heart failure.

Under § 718.204(b)(2)(iv), total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

As outlined above, the record contains the medical opinions of Drs. Hasson (DX 19, 62), Goldstein (DX 20), Hall (DX 22; CX 7), Russakoff (DX 7), Vincent (DX 22), Waldrum (DX 58, 61, 62), and Cohen (CX 1).

In summary, Dr. Hasson did not find pneumoconiosis in 1979. However, in 1999, Dr. Hasson diagnosed simple pneumoconiosis and found a mild impairment. Dr. Hasson, however, failed to specifically address the question of whether such impairment would prevent the Claimant from performing his last usual coal mine job as a motorman. In 1989, Dr. Goldstein reported some abnormalities which he suggested were cardiac and/or smoking-related. He did not diagnose pneumoconiosis nor did he find the Claimant significantly impaired. In Dr. Hall's 1990 report, he listed pneumoconiosis and COPD among various diagnosed conditions, but he did not address the total disability issue. In his August 9, 2000 report, however, Dr. Hall specifically found that the Claimant is totally disabled from anything more than sedentary work, and that such disability is due to pneumoconiosis. In 1992, Dr. Russakoff diagnosed minimal pneumoconiosis. As stated above, Dr. Russakoff's assessment regarding the severity of Claimant's respiratory impairment is somewhat ambiguous. Moreover, Dr. Russakoff appears to relate Claimant's problems to conditions other than pneumoconiosis. In 1993, Dr. Vincent diagnosed pneumoconiosis and found that the Claimant was totally disabled from any gainful employment due to his shortness of breath. Dr. Waldrum treated the Claimant for parts of 1998 and 1999. Although he clearly diagnosed pneumoconiosis and reported that the Claimant was totally disabled therefrom, Dr. Waldrum's deposition testimony suggests that he did not really know the full extent of Claimant's respiratory or pulmonary impairment. Thus, the essence of Dr. Waldrum's opinion was simply that the Claimant should not be exposed to further coal mine dust, in view of his pneumoconiosis. Finally, Dr. Cohen provided a detailed analysis of the medical evidence in his August 29, 2000 report. Dr. Cohen found complicated and simple pneumoconiosis on x-ray. Furthermore, he analyzed the pulmonary function studies and the diffusion testing, in conjunction with the physical requirements of the Claimant's last usual coal mine job. Based upon the foregoing, Dr. Cohen opined that Claimant's respiratory impairment would preclude him from performing his last usual coal mine job as a motorman.

Having carefully weighed all of the medical opinion evidence, I find that the Claimant has developed a totally disabling respiratory or pulmonary impairment. As summarized above, the early medical opinion evidence fails to establish total disability. However, in view of the progressive nature of pneumoconiosis, greater weight is generally accorded the more recent medical evidence. Since Dr. Russakoff's somewhat ambiguous report, dated October 21, 1992 (DX 7), Drs. Vincent (DX 22), Cohen (CX 1) and Hall (CX 7) have all found that the Claimant suffers from a respiratory or pulmonary impairment which would prevent him from performing his last usual coal mine job as a motorman.[6]

For the reasons set forth in the Board's Decision and Order, dated March 30, 1995 (DX 37) and in Judge Murty's Decision and Order, dated July 23, 1998 (DX 57), I find that Dr. Vincent's opinion would not, in and of itself, warrant a finding of total disability. However, I find that the recent medical opinions of Drs. Cohen and Hall establish total disability. Although Dr. Cohen, a B-reader and Board-certified pulmonary specialist, erroneously found complicated pneumoconiosis by x-ray, his report, dated August 29, 2000, is thorough, well reasoned and documented. In finding total disability, Dr. Cohen takes into account the nonqualifying, albeit abnormal, clinical test results in conjunction with the physical requirements of the Claimant's last usual coal mine job. Moreover, in his discussion of the total disability issue, Dr. Cohen focused on Claimant's abnormal pulmonary function and diffusion test results, *not* his x-ray finding of complicated pneumoconiosis. Furthermore, Dr. Cohen's opinion is buttressed by the report of Dr. Hall, the Claimant's treating physician. Although Dr. Hall's report lacked some of the detail of Dr. Cohen's report, it, too, discussed the Claimant's coal mine employment and smoking histories, the nature of Claimant's last usual coal mine job, Claimant's subjective complaints of significant respiratory impairment, and referred to a recent abnormal cardiopulmonary exercise study. Therefore, I find that total disability has been established under § 718.204(b)(2)(iv).

Having found total disability on the basis of the medical opinion evidence, I must weigh all of the contrary and probative evidence together to determine if Claimant has established total disability under Section 718.204(b) overall. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986).

Based upon my thorough review of the entire record, I find that the early medical data failed to establish either pneumoconiosis or total disability therefrom. Over the years, however, the x-ray evidence has clearly and unequivocally established the presence of simple pneumoconiosis. This is consistent with the progressive nature of the disease. Similarly, the medical opinion evidence establishes that the Claimant's respiratory condition has worsened. Notwithstanding the nonqualifying results obtained on pulmonary function studies and arterial blood gas tests, the clinical evidence reveal

---

[6]Dr Waldrum's report also stated that the Claimant is totally disabled from performing his last usual coal mine job due to pneumoconiosis. However, Dr. Aldrum's deposition testimony indicates that he simply found that the Claimant should avoid further coal mine dust exposure (DX 58, 61, 62).

some abnormalities. If the Claimant had a sedentary job which required only minimal exertion, such abnormalities would not warrant a finding of total disability. However, based upon the evidence presented, including Claimant's testimony, I find that the Claimant's last usual coal mine job a motorman entailed considerable lifting and carrying. Accordingly, the abnormal, albeit nonqualifying, results on clinical testing are consistent with the most recent medical opinions of Drs. Cohen and Hall, who both found that the Claimant is totally disabled. Therefore, taken as a whole, I find that total disability has been established under amended § 718.204(b).

Causation

Having found that the Claimant suffers from pneumoconiosis arising from his coal mine work, and that he is totally disabled by his respiratory or pulmonary impairment, Claimant still has the burden of establishing that the disability is due to pneumoconiosis.

Under the provisions of amended § 718.204(c)(1), a "miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." Furthermore, the regulations state, in pertinent part:

> ...Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:
> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1)(i),(ii).

As discussed above, the early medical evidence failed to establish total disability. The recent medical opinions of Drs. Cohen and Hall, however, not only establish that the Claimant is totally disabled by his respiratory or pulmonary impairment, but also that such disability is due to his pneumoconiosis and his 37 years of underground coal dust exposure.[7] I find their opinions are well-reasoned and documented regarding this issue, and consistent with the Claimant's long history of coal mine dust exposure, positive chest x-ray evidence of pneumoconiosis, subjective complaints of worsening breathing problems, and abnormalities on various clinical tests. Therefore, I find that Claimant's pneumoconiosis is, at least, a substantially contributing cause of his total disability. 20 C.F.R. § 718.204(c)(1).

---

[7]Although there may be other possible contributing factors, such as Claimant's smoking history and injuries sustained in a car accident, I note that Claimant smoked only two packs per week before quitting. Furthermore, Claimant fractured his ribs in 1977, but returned to work as a coal miner for an additional 12 years.

Conclusion

Having considered all of the evidence, I find that the Claimant has established a material change in conditions; that he has pneumoconiosis arising, at least in part, from his approximately 37 years of coal mine employment; and that pneumoconiosis was at least a substantially contributing cause of such total disability. Therefore, he is entitled to benefits under the Act.

Commencement of Entitlement to Benefits

Under § 725.503(b), the date for commencement of benefits is the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. However, where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed. 20 C.F.R. § 725.503(b).

In the present case, the Claimant's work history, the objective clinical studies, and the credible medical opinion evidence establish that the Claimant has developed pneumoconiosis and total disability therefrom, since his prior two claims were finally denied. However, the evidence does not establish the month of onset of total disability due to pneumoconiosis. Accordingly, benefits shall commence as of August 1, 1992, the month during which the current claim was filed.

ORDER

The claim of London Sims for benefits under the Act is **GRANTED**. It is hereby **ORDERED** that U.S. Steel Mining Company, Inc. and USX Corporation, its Carrier, pay Claimant all benefits to which he is entitled under the Act commencing as of August 1, 1992.

It is further **ORDERED** that U.S. Steel Mining Company, Inc. and USX Corporation, its Carrier, shall reimburse the Secretary of Labor for payments under the Act made to the Claimant, if any, and deduct such amount, as appropriate, from the amount it is ordered to pay under the preceding paragraph above.

A
ROBERT J. LESNICK
Administrative Law Judge

RJL:mr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 22013-7601.*** A copy of a notice of appeal must also be served on Donald S.

Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.